SOLIS
HEALTH PLANS

SPF-001 HMO

2022

SUMMARY OF BENEFITS
SPF 001 (HMO)

H0982_SUMBNF0012022_M

2022
SUMMARY OF BENEFITS

SPF-001 HMO

SOLIS Health Plans SPF 001 (HMO)

January 1, 2022 - December 31, 2022

H0982, Plan 001 - Miami-Dade County

Solis Health Plan is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

This summary of benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage" (EOC) online at www.solishealthplans.com or call us and request a copy.

What does Solis Health Plans (HMO) Cover?

Like all Medicare health plans, we cover everything that Original Medicare covers—**and more!**

- ✓ Our members receive more benefits than are covered by Original Medicare. Some of these supplemental benefits are outlined in this Summary of Benefits.
- ✓ We cover Part D drugs. You can see Solis's Comprehensive Prescription Drug List (formulary) on our website at www.solishealthplans.com or call toll-free 1 (844) 447-6547 (TTY 711).
- ✓ Solis has a network of hospitals, doctors, specialists, pharmacies, and other providers ready to serve all of your healthcare needs. You can access the Provider Directory on our website at www.solishealthplans.com or call toll-free 1 (844) 447-6547 (TTY 711). Services are available when using an in-network provider. Out of network provider services are not covered except in emergency situations.

Medicare Plan Finder on www.medicare.gov allows you to compare our plan with other plans for their Summary of Benefits.

If you are already a member of Solis Health Plans, call toll-free 1 (844) 447-6547 (TTY 711). Customer Service is available October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday 8 a.m. – 8 p.m. local time. Our automated phone system may answer your call weekends, holidays and after hours.

To join **Solis Health Plan (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes the following counties in Florida: **Miami- Dade.**

For coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This document is available in other formats such as braille, large print or audio.

For more information, please call us at 1 (844) 447-6547 / (TTY : 711), or visit us at https://solishealthplans.com. 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1 (844) 447-6547, TTY 711.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit www.solishealthplans.com or call 1 (844) 447-6547, TTY 711 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2023.
- ☐ Except in certain emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

SPF 001 (HMO) H0982-001

Monthly Plan Premium

- $0
- You must continue to pay your Part B premium.

Deductible

- No deductible

Maximum Out-of-Pocket Responsibility (does not include prescription drugs)

- $3,400 In-network
- Includes copays and other costs for medical services for the year

Covered Medical and Hospital Benefits

Inpatient Hospital[A,R]

- $0 Copayment

Outpatient Hospital[A,R]

- $25 Copayment per observation or per stay

Doctor Visits

• Primary Care:	$0 Copayment
• Specialists:[A,R]	$0 Copayment

Authorization not required for initial evaluation
Authorization may be required for subsequent visits

A - Authorization may be required **R** - Referral may be required

Preventive Care

- $0 Copayment
  - Abdominal aortic aneurysm screening[R]
  - Annual “wellness” visit
  - Bone mass measurement[R]
  - Breast cancer screening (mammogram)[R]
  - Cardiovascular disease risk reduction visit
  - Cardiovascular disease testing[R]
  - Cervical and vaginal cancer screening[R]
  - Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)[A,R]
  - Depression screening
  - Diabetes screenings
  - HIV screening
  - Immunizations
  - Lung cancer screenings[R]
  - Medical nutrition therapy[R]
  - Medicare Diabetes prevention program[R]
  - Obesity screenings and therapy[R]
  - Prostate cancer screenings (PSA)
  - Screening and counseling to reduce alcohol misuse
  - Sexually transmitted infections screenings and counseling[R]
  - Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)[R]
  - “Welcome to Medicare” preventive visit (one-time)

A - Authorization may be required **R** - Referral may be required

Emergency Care / Post-Stabilization Care[A]

- $25 Copayment - waived if admitted to hospital within 1 day
- International Emergencies - $50,000 annual benefit max
  - $25 Copayment - waived if admitted to hospital

Urgently Needed Services

- $0 Copayment

Outpatient Care and Services

Diagnostic Services/Labs/Imaging

Medicare-covered Diagnostic Procedures / Tests:[R]
- $0 Copayment - In Network Non-Hospital Facility
- $20 Copayment - Hospital Facility

Medicare-covered Lab Services:[R]
- $0 Copayment

Medicare-covered X-Ray Services:[A,R]
- $0 Copayment - In Network Non-Hospital Facility
- $20 Copayment - Hospital Facility

Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc.):[A,R]
- $0 Copayment - In Network Non-Hospital Facility
- $35 Copayment - Hospital Facility

Medicare-covered Therapeutic Radiological Services:[A,R]
- 20% Coinsurance

A - Authorization may be required **R** - Referral may be required

Hearing Services

Hearing Services (Routine Hearing Exam and Hearing Aid)[A,R]

- $0 Copayment
- $3,000 Hearing Aid allowance both ears combined per year
- Unlimited Routine Hearing Exams

Dental Services

Preventive[R]

• Oral Exam	$0 Copayment – 2 exams every year
• Cleaning	$0 Copayment – 2 every year
• Fluoride Treatment	$0 Copayment – 2 every year
• Dental X-Rays	$0 Copayment – 2 every year

Comprehensive[A,R]

• Diagnostic Services	$0 Copayment – 2 visits every year
• Restorative Services	$0 Copayment – 6 visits every year
• Endodontics	$0 Copayment – 1 visit every 2 years
• Periodontics	$0 Copayment – 4 visits every year
• Extractions	$0 Copayment – 5 extractions every year
• Prosthodontics, Other Oral/ Maxillofacial Surgery, Other Services	$0 Copayment – 2 visits every 2 years

A - Authorization may be required

R - Referral may be required

Vision Services

Vision Services[A,R]

- Eye exams: $0 Copayment – 1 exam every year

- Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades:[A,R]
- $0 Copayment $400 annual total allowance

Additional Outpatient Care and Services

Mental Health Services

- Inpatient hospital (Psychiatric)[A,R] $0 Copayment

- Mental Health Specialty Services[R] $0 Copayment

Skilled Nursing Facility (SNF)[A,R]

- $0 Copayment, days 1-20
- $50 Copayment per day, for days 21-100

2 day prior network hospital admissions prerequisite

Rehabilitation Services (Physical Therapy and Speech Language Pathology Services)[A,R]

- $0 Copayment

Authorization not required for initial evaluation
Authorization may be required for subsequent visits

A - Authorization may be required **R** - Referral may be required

Ambulance[A]

- Medicare-covered Air Ambulance Services:
  20% Coinsurance - waived if admitted to hospital

- Medicare-covered Ground Ambulance Services:
  $40 Copay - waived if admitted to hospital

Authorization is required for non-emergency Medicare services

Transportation[R]

- $0 Copayment

Unlimited trips to plan approved health-related locations

Additional Benefits

Medicare Part B Drugs and Home Infusion Drugs[A]

- 20% Coinsurance

Erectile Dysfunction Drugs (ED)

- You are covered for up to 6 pills per month

Ambulatory Surgical Center[A,R]

- $0 Copayment

Fitness[R]

- $0 Copayment

Silver & Fit - Gym Membership

Podiatry Services[A,R]

- $0 Copayment

Unlimited Routine Care
Authorization not required for initial evaluation
Authorization may be required for subsequent visits

A - Authorization may be required **R** - Referral may be required

Meals[A]

• $0 Copayment - 2 meals a day for 7 days

Meals are covered immediately following surgery or inpatient hospitalization.

Meals are covered immediately following each surgery or inpatient hospitalization for unlimited hospitalizations

Medical Equipment/Supplies

• Diabetic Supplies	$0 Copayment
• Diabetic Therapeutic Shoes or Inserts[A]	20% Coinsurance

Diabetic Supplies and Services limited to those from specified manufacturers

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• Durable Medical Equipment[A] - Medicare-covered ventilators - bone growth stimulators - portable oxygen concentrators - bariatric equipment - specialty beds - custom wheelchairs - seat lifts - specialty brand items.	20% Coinsurance
• All other Durable Medical Equipment	0% Coinsurance
• Prosthetic Devices[A] - Medicare-covered prosthetic devices	20% Coinsurance

The plan has preferred vendors / manufacturers for Durable Medical Equipment (DME)

A - Authorization may be required **R** - Referral may be required

Over-the-Counter (OTC)

• $0 Copayment

The plan covers up to $75 per month for plan approved over-the-counter and health-related products.

Acupuncture[A,R]

• $0 Copayment

Up to 12 visits in 90 days. An additional 8 sessions will be covered for those patients demonstrating an improvement.

No more than 20 acupuncture treatments may be administered annually

Chiropractic Services[A,R]

• $0 Copayment for Medicare-covered Chiropractic Services

Unlimited Routine Care

Authorization required after first 12 visits

A - Authorization may be required **R** - Referral may be required

Prescription Drug Benefits

Prescription Drugs

Deductible Stage	The plan has no deductible stage			
	Standard Retail Rx 30-day Supply	Standard Retail Rx 90-day Supply	Out-of-Network Retail Rx 90-day Supply	Mail Order 90-day Supply
Initial Coverage - You stay in this stage until your year-to-date "total drug costs" (your payments plus any Part D plan's payments) total $7,000.				
Tier 1: Preferred Generic	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 2: Generic	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 3: Preferred Brand	$0 Copay	$0 Copay	$0 Copay	Not Available
Tier 4: Non-Preferred	$10 Copay	$25 Copay	$10 Copay	Not Available
Tier 5: Specialty	33% Coinsurance	Not Available	33% Coinsurance	Not Available
Tier 6: Supplemental Drugs	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Coverage Gap - Your stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of $7,050				
Tier 1: Preferred Generic	$0 Copay	$0 Copay	$0 Copay	$0 Copay
Tier 2: Generic	$0 Copay	$0 Copay	$0 Copay	$0 Copay
For all other drugs, you pay 25% coinsurance for generic drugs and 25% coinsurance for brand-name drugs.				

	Standard Retail Rx 30-day Supply	Standard Retail Rx 90-day Supply	Out-of-Network Retail Rx 90-day Supply	Mail Order 90-day Supply
Catastrophic Coverage- During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2022).				
Tier 1: Preferred Generic	You pay either 5% of the cost of the drug or $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs. (whichever is the larger amount)	You pay either 5% of the cost of the drug or $3.95 for a generic drug or a drug that is treated like a generic and $9.85 for all other drugs. (whichever is the larger amount)
Tier 2: Generic				
Tier 3: Preferred Brand				
Tier 4: Non-Preferred				
Tier 5: Specialty				
Tier 6: Supplemental Drugs	$0 Copay	$0 Copay	$0 Copay	$0 Copay

Individuals with "Extra Help" will pay a different copayment or coinsurance amount for Part D drugs. The amount you will pay depends on your qualified level. The table below demonstrates what you will pay if you qualify for "Extra Help" and how much you will pay in the different levels.

"Extra Help" Level	Your cost sharing amount for generic/preferred multi-source drugs is no more than	Your cost sharing amount for all other drugs is no more than
Level 1	$3.95	$9.85
Level 2	$1.35	$4.00
Level 3	$0	$0
Level 4	15% Coinsurance	15% Coinsurance

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This information is not a complete description of benefits.
Call 1 (844) 447-6547 / (TTY : 711) 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31
8 a.m. to 8 p.m. Monday-Friday from April 1 - Sept. 30 for more information.